

Patient's Name: _____
(Last) (First) (M.I.)
Street Address: _____
(Number, Street, City, State) Zip Code) _____

REPORT OF VERIFIED CASE
OF TUBERCULOSIS



DEPARTMENT OF HEALTH & HUMAN SERVICES
PUBLIC HEALTH SERVICE
CENTERS FOR DISEASE CONTROL
AND PREVENTION (CDC)
ATLANTA, GEORGIA 30333

REPORT OF VERIFIED CASE OF TUBERCULOSIS

FORM APPROVED OMB NO. 0920-0026 Exp. Date 09/30/2005

Initial Drug Susceptibility Report

(Follow Up Report – 1)

SOUNDEX <div><div></div><div></div><div></div><div></div></div>	State Reporting: Specify: _____ Alpha State Code <div><div></div><div></div></div>	Year Counted: <div><div></div><div></div></div>	State Case Number: <div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div></div> City/County Case Number: <div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div></div>
---	---	---	--

Submit this report for all culture-positive cases.

33. Initial Drug Susceptibility Results:

Was Drug Susceptibility Testing Done: 0 ☐ No 1 ☐ Yes 9 ☐ Unknown

If answer is No or Unknown, do not complete rest of report.

If Yes,
Enter Date First Isolate Collected
for Which Drug Susceptibility Was Done?

Mo. Day Yr.

34. Susceptibility Results:

	<u>Resistant</u>	<u>Susceptible</u>	<u>Not Done</u>	<u>Unknown</u>
Isoniazid	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>
Rifampin	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>
Pyrazinamide	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>
Ethambutol	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>
Streptomycin	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>
Ethionamide	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>
Kanamycin	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>
Cycloserine	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>
Capreomycin	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>
Para-Amino Salicylic Acid	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>
Amikacin	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>
Rifabutine	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>
Ciprofloxacin	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>
Ofloxacin	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>
Other	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>

Comments:

.....

.....

.....

Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Project Clearance Officer, 1600 Clifton Road, MS D-24, Atlanta, GA 30333, ATTN: PRA (0920-0026). Do not send the completed form to this address.

Information contained on this form which would permit identification of any individual has been collected with a guarantee that it will be held in strict confidence, will be used only for surveillance purposes, and will not be disclosed or released without the consent of the individual in accordance with Section 308(d) of the Public Health Service Act (42 U.S.C. 242m).

Patient's Name: _____
(Last) (First) (M.I.)
Street Address: _____
(Number, Street, City, State) Zip Code: _____

REPORT OF VERIFIED CASE
OF TUBERCULOSIS



REPORT OF VERIFIED CASE OF TUBERCULOSIS

DEPARTMENT OF HEALTH & HUMAN SERVICES
PUBLIC HEALTH SERVICE
CENTERS FOR DISEASE CONTROL
AND PREVENTION (CDC)
ATLANTA, GEORGIA 30333

FORM APPROVED OMB NO. 0920-0026 Exp. Date 09/30/2005

Case Completion Report

(Follow Up Report – 2)

SOUNDEX [][][][]	State Reporting: Specify: _____ Alpha State Code [][]	Year Counted: [][]	State Case Number: [][][][][][][][][]
			City/County Case Number: [][][][][][][][][]

Submit this report for all cases in which the patient was alive at diagnosis.

35. Sputum Culture Conversion Documented: 0 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes 9 <input type="checkbox"/> Unknown If Yes, Date Specimen Collected on Initial Positive Sputum Culture: Mo. [][] Day [][] Yr. [][] If Yes, Date Specimen Collected on First Consistently Negative Culture: Mo. [][] Day [][] Yr. [][]																																																																																	
36. Date Therapy Stopped: Mo. [][] Day [][] Yr. [][]	37. Reason Therapy Stopped: 1 <input type="checkbox"/> Completed Therapy 3 <input type="checkbox"/> Lost 5 <input type="checkbox"/> Not TB 7 <input type="checkbox"/> Other 2 <input type="checkbox"/> Moved 4 <input type="checkbox"/> Uncooperative or Refused 6 <input type="checkbox"/> Died 9 <input type="checkbox"/> Unknown																																																																																
38. Type of Health Care Provider: 1 <input type="checkbox"/> Health Department 2 <input type="checkbox"/> Private/Other 3 <input type="checkbox"/> Both Health Department and Private/Other 9 <input type="checkbox"/> Unknown	39. Directly Observed Therapy: 0 <input type="checkbox"/> No, Totally Self-Administered 1 <input type="checkbox"/> Yes, Totally Directly Observed 2 <input type="checkbox"/> Yes, Both Directly Observed and Self-Administered 9 <input type="checkbox"/> Unknown If Yes, Give Site(s) of Directly Observed Therapy: 1 <input type="checkbox"/> In Clinic or Other Facility 2 <input type="checkbox"/> In the Field 3 <input type="checkbox"/> Both in Facility and in the Field 9 <input type="checkbox"/> Unknown Number of Weeks of Directly Observed Therapy: Weeks [][][]																																																																																
40. Final Drug Susceptibility Results: Was Follow-up Drug Susceptibility Testing Done? 0 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes 9 <input type="checkbox"/> Unk. If answer is No or Unknown, do not complete rest of report. If Yes, Enter Date Final Isolate Collected for Which Drug Susceptibility Was Done: Mo. [][] Day [][] Yr. [][]																																																																																	
41. Final Susceptibility Results: <table border="1"><thead><tr><th></th><th>Resistant</th><th>Susceptible</th><th>Not Done</th><th>Unknown</th></tr></thead><tbody><tr><td>Isoniazid</td><td>1 <input type="checkbox"/></td><td>2 <input type="checkbox"/></td><td>3 <input type="checkbox"/></td><td>9 <input type="checkbox"/></td></tr><tr><td>Rifampin</td><td>1 <input type="checkbox"/></td><td>2 <input type="checkbox"/></td><td>3 <input type="checkbox"/></td><td>9 <input type="checkbox"/></td></tr><tr><td>Pyrazinamide</td><td>1 <input type="checkbox"/></td><td>2 <input type="checkbox"/></td><td>3 <input type="checkbox"/></td><td>9 <input type="checkbox"/></td></tr><tr><td>Ethambutol</td><td>1 <input type="checkbox"/></td><td>2 <input type="checkbox"/></td><td>3 <input type="checkbox"/></td><td>9 <input type="checkbox"/></td></tr><tr><td>Streptomycin</td><td>1 <input type="checkbox"/></td><td>2 <input type="checkbox"/></td><td>3 <input type="checkbox"/></td><td>9 <input type="checkbox"/></td></tr><tr><td>Ethionamide</td><td>1 <input type="checkbox"/></td><td>2 <input type="checkbox"/></td><td>3 <input type="checkbox"/></td><td>9 <input type="checkbox"/></td></tr><tr><td>Kanamycin</td><td>1 <input type="checkbox"/></td><td>2 <input type="checkbox"/></td><td>3 <input type="checkbox"/></td><td>9 <input type="checkbox"/></td></tr><tr><td>Cycloserine</td><td>1 <input type="checkbox"/></td><td>2 <input type="checkbox"/></td><td>3 <input type="checkbox"/></td><td>9 <input type="checkbox"/></td></tr><tr><td>Capreomycin</td><td>1 <input type="checkbox"/></td><td>2 <input type="checkbox"/></td><td>3 <input type="checkbox"/></td><td>9 <input type="checkbox"/></td></tr><tr><td>Para-Amino Salicylic Acid</td><td>1 <input type="checkbox"/></td><td>2 <input type="checkbox"/></td><td>3 <input type="checkbox"/></td><td>9 <input type="checkbox"/></td></tr><tr><td>Amikacin</td><td>1 <input type="checkbox"/></td><td>2 <input type="checkbox"/></td><td>3 <input type="checkbox"/></td><td>9 <input type="checkbox"/></td></tr><tr><td>Rifabutine</td><td>1 <input type="checkbox"/></td><td>2 <input type="checkbox"/></td><td>3 <input type="checkbox"/></td><td>9 <input type="checkbox"/></td></tr><tr><td>Ciprofloxacin</td><td>1 <input type="checkbox"/></td><td>2 <input type="checkbox"/></td><td>3 <input type="checkbox"/></td><td>9 <input type="checkbox"/></td></tr><tr><td>Ofloxacin</td><td>1 <input type="checkbox"/></td><td>2 <input type="checkbox"/></td><td>3 <input type="checkbox"/></td><td>9 <input type="checkbox"/></td></tr><tr><td>Other</td><td>1 <input type="checkbox"/></td><td>2 <input type="checkbox"/></td><td>3 <input type="checkbox"/></td><td>9 <input type="checkbox"/></td></tr></tbody></table>			Resistant	Susceptible	Not Done	Unknown	Isoniazid	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	Rifampin	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	Pyrazinamide	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	Ethambutol	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	Streptomycin	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	Ethionamide	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	Kanamycin	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	Cycloserine	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	Capreomycin	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	Para-Amino Salicylic Acid	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	Amikacin	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	Rifabutine	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	Ciprofloxacin	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	Ofloxacin	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>	Other	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>
	Resistant	Susceptible	Not Done	Unknown																																																																													
Isoniazid	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>																																																																													
Rifampin	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>																																																																													
Pyrazinamide	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>																																																																													
Ethambutol	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>																																																																													
Streptomycin	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>																																																																													
Ethionamide	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>																																																																													
Kanamycin	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>																																																																													
Cycloserine	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>																																																																													
Capreomycin	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>																																																																													
Para-Amino Salicylic Acid	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>																																																																													
Amikacin	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>																																																																													
Rifabutine	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>																																																																													
Ciprofloxacin	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>																																																																													
Ofloxacin	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>																																																																													
Other	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	9 <input type="checkbox"/>																																																																													

Comments:

.....

.....

.....

.....

Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Project Clearance Officer, 1600 Clifton Road, MS D-24, Atlanta, GA 30333, ATTN: PRA (0920-0026). Do not send the completed form to this address.

Information contained on this form which would permit identification of any individual has been collected with a guarantee that it will be held in strict confidence, will be used only for surveillance purposes, and will not be disclosed or released without the consent of the individual in accordance with Section 308(d) of the Public Health Service Act (42 U.S.C. 242m).

1st Copy

2nd Copy

3rd Copy

PRINTER NOTE

**PLEASE STRIP-IN ABOVE COPY NAMES ON
CENTER BOTTOM OF REQUIRED COPY PAGE**